STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) A. BUILDING: <b>01</b>			(X3) DATE SURVEY COMPLETED	
			A. BOILDING. VI			
		FCL009008	B. WING		05/2	2/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
OAK GR	OVE FAMILY CARE H	OME	AFRAS ROAD BORO, NC 2			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ( MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
C 000	Initial Comments		C 000			
	Report by Suzanna DHSR Construction	•				
	DHSR Construction Section conducted a Biennial Survey on May 22, 2015 from 8:24 AM to 9:35 AM at the above referenced facility. DHSR records indicate the home was first licensed on June 15, 1984 as a Family Care Home for six ambulatory Residents (able to evacuate and respond without any physical or verbal assistance during a fire or other emergency). Based on this information we are requiring the home to maintain compliance with the following: the 1984 Family Care Homes Minimum Standards and Regulations, applicable portions of the 2005 Rules 10A NCAC 13G for Family Care Homes and the 1978 (Revision 5) North Carolina State Building Code - Section 409.1 (g) - Residential Care Facilities.  At the time of our visit, we cited deficiencies that require an acceptable plan of correction. They are as follows:					
C 117	Have Current San.	And Fire Safety Approvals	C 117			
	CONSTRUCTION (n) The home sha fire and building sa	THE BUILDING 802 DESIGN AND Il have current sanitation and fety inspection reports which I in the home and available for				
	Inspection performe 2014. Fire Inspecti conducted annually	et as evidenced by: v of documents, the last Fire ed at the facility was March 17, ons are required to be v. Contact the local fire official pection. Provide a copy of the				

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE TITLE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					3) DATE SURVEY COMPLETED	
	FCL009008		B. WING		05/22/2015	
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE	03/2	2/2013
		583 SASA	FRAS ROAL			
UAN GR	OVE FAMILY CARE H	BLADENE	ORO, NC 2	8320		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
C 117	Continued From pa	ge 1	C 117			
	approved report to	DHSR/Construction Section.				
C 153	Houskeeping And F	urnishings-Clean, Repaired	C 153			
	SECTION .0300 - THE BUILDING 10A NCAC 13G .0315 HOUSEKEEPING AND FURNISHINGS (a) Each family care home shall: (1) have walls, ceilings, and floors or floor coverings kept clean and in good repair; (2) have no chronic unpleasant odors; (3) have furniture clean and in good repair; (e) This Rule shall apply to new and existing homes.					
	on the back wall ha were taped and mu painted. The curtai	it was observed that a window d been removed. The walls dded, but have not been n brackets were still mounted ing. Have a qualified person				
C 168	Fire Extinguishers		C 168			
	DISASTER PLAN  (a) Fire extinguish meet these minimu care home:  (1) one five pound type centrally located (2) one five pound type located in the limited in	ers shall be provided which m requirements in a family or larger (net charge) "A-B-C" ed; or larger "A-B-C" or CO/2 kitchen; and ion as determined by the code I.				

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FCL009008		B. WING		05/22/2015		
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
OAK GR	OVE FAMILY CARE H	OME	FRAS ROAD			
	BLADEN					
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C 168	Continued From pa	ge 2	C 168			
	2014 and are past	vealed that the fire last serviced in February of due for their annual inspection. rson inspect and tag the fire				
C 174	Building Equipment	Maintained Safe, Operating	C 174			
	EQUIPMENT (a) The building at mechanical, and plucare home shall be operating condition	and all fire safety, electrical, umbing equipment in a family maintained in a safe and apply to new and existing				
	outside of the staff wires. When the sr with canned smoke	is survey, the smoke detector bedroom was hanging from its moke detector was sprayed the alarm was barely alified person repair or detector. Provide				
	on the Resident had not interconnected in the facility. Have replace the smoke	is survey, the smoke detector II nearest the living room was to the other smoke detectors a qualified person repair or detector so that when any one d, all of the detectors sound.				
	in Bedroom #1 and interconnected to the	is survey, the smoke detectors in Bedroom #4 were not ne other smoke detectors in qualified person repair or				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′ CON			ATE SURVEY OMPLETED	
7.11.2.1.2.11	or contraction	ISEITTII 16, TIGIT NOMBER.	A. BUILDING:	01	001111	
		FCL009008	B. WING		05/2	2/2015
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
OAK GR	OVE FAMILY CARE H	OME	FRAS ROAD BORO, NC 2			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROINT DEFICIENCY)	D BE	(X5) COMPLETE DATE
C 174	Continued From pa	ge 3	C 174			
	replace the smoke detector so that when any one detector is activated, all of the detectors sound. Provide documentation of the repairs.					
	4. Observations revealed that the exterior outlet on the front porch did not have power. Have a qualified technician repair or replace the outlet. Provide documentation of the repairs.					
	5. Observations revealed that the latch on the window in Bedroom #3 was broken. Have a qualified person repair the window. Provide documentation of the repairs.					
	6. Observations revealed that the light in the master bath did not have a globe. Have a qualified person install a globe. Provide documentation of the repairs.					
	7. Observations revealed the the exhaust fan in the master bath was clogged with dust. Clean the fan and provide verification that the correction is complete.					
	hood was dirty and Have a qualified pe	vealed that the kitchen range the grease filter was missing. rson install a grease filter and od. Provide documentation of				
	the exterior dryer ca					
	the carport at the codamaged. Have a	evealed that the metal roof of or				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					X3) DATE SURVEY COMPLETED	
			A. BOILDING. VI			
		FCL009008	B. WING		05/2	2/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
OAK GR	OVE FAMILY CARE H	IOME	FRAS ROAL			
(VA) ID	CLIMMA DV CTA	ATEMENT OF DEFICIENCIES	BORO, NC 2	PROVIDER'S PLAN OF CORRECT	ION	(VE)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
C 101	Construction-Single  IV. The Building	e Family	C 101			
	IV. The Building B. General Construction and Maintenance (10NCAC 42C .2102) 1. The home must meet the single family residential building code requirements of North Carolina Insurance Department. In addition, the following apply to facilities licensed after February 1, 1983, facilities which increase bed capacity,					
	and facilities which change ownership.  This Rule is not met as evidenced by:  1. At the time of this survey the following observations were made:					
	internally connected b. The addition red pickup truck was c. Lawn chairs miscellaneous item main entry to the act Staff, she stated the d. Interview wi building was once ustorage, but was cue. The porch li window A/C units was f. The facility hinterview with Staff which she said was g. The addition and would, therefor family care home.	n has a separate drive and a as parked in the drive. It, coolers and other as were sitting in front of the addition. Per interview with at most of the items were hers. It has a state of the items were hers. It has a state of the items were hers. It has a state of the items were hers. It has a state of the items were hers. It has a state of the items were hers. It has a state of the items and one of the items are a dryer connection and per it also has a small kitchen is no longer used. In it is not separated by a fire wall re, be classified as part of the				
	and, therefore, can	ified as a single family dwelling not have renters or boarders. tion is not being used for rent				

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STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING: <b>01</b>		SURVEY LETED	
FCL009008		B. WING		05/22/2015			
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE			
OAK GR	OVE FAMILY CARE H	ONE	AFRAS ROAD BORO, NC 2				
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE	
C 101	Continued From pa	ge 5	C 101				
	or boarding.						
C 119	Bathroom		C 119				
	have one full bathropersons including lib. If there is a questore April 1, 1984 bathrooms, the Diviresponsible for determined of bathrooms requires persons living in the c. The bathroom (signivacy. A bathroom tub/shower must hacurtains.  d. Entrance to the last a kitchen, another pathroom.  e. The bathroom maconveniently as postedrooms. f. Hand grips must tubs and showers or residents. g. Nonskid surfacir in showers and bath h. The bathroom madequately ventilated in the bathroom flowater-resistant coveres.	cAC 42C .2206) ed as of April 1, 1984 must from for each five or fewer ve-in staff and family. stion whether a home licensed has a sufficient number of ision of Facility Services is ermining the size and number red based on the number of e home. ) must be designed to provide m with more than one toilet or ave privacy partitions or bathroom is not to be through person 's bedroom, or another must be located as esible to the resident 's t be installed at all commodes, on the floor level used by the mg or strips must be installed h areas. must be well lighted and ed. cor must have a non-slippery ering.					
	This Rule is not me 1. Observations rev	et as evidenced by: vealed that the Residents' hall					

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	<u>of Health Service Re</u>	eguiation				
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING: <b>01</b>		(X3) DATE SURVEY COMPLETED		
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C 119	Continued From pa	ge 6	C 119			
	Have a qualified pe	ave a hand grip for the tub. rson install a hand grip at the nentation of the repairs.				
C 123	Outside Entrances/	Exits	C 123			
	tub. Provide documentation of the repairs.  Outside Entrances/Exits  IV. The Building C. Physical Environment 8. Outside Entrances/Exits (10 NCAC 42C .2209) a. All floor levels must have at least two exits. If there are only two, the exits must be as remote from each other as reasonably possible. b. At least one entrance/exit door must be a minimum clear width of three feet and another must be a minimum clear width of two feet and eight inches. c. At least two outside entrances/exits for the residents' floor level must be at ground level or accessible by ramp with a 1 inch rise for each 12 inches of length of the ramp. If there are only two entrances/exits, the entrances/exits must be as remote from each other as reasonably possible. (The requirement for the ramp at exits not at ground level applies to homes which have at least one resident who needs personal assistance in getting up or down steps.) d. All exit door locks must be easily operable, by a single hand motion, from the inside at all times without keys. e. All entrances/exit must be free of all obstructions or impediments to allow for full instant use in case of fire or other emergency. f. All steps, porches, stoops and ramps must be provided with handrails and guardrails.  This Rule is not met as evidenced by: 1. Observations revealed that the kitchen exit					

DIVISION	of Fleatiff Service INC	guiation				
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA					X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: <b>01</b>		COMPLETED	
		FCL009008	B. WING		05/2	2/2015
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
		583 SASA	FRAS ROAL			
OAK GRO	OVE FAMILY CARE H	OME BLADENE	ORO, NC 2	8320		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD		D BE	(X5) COMPLETE DATE
C 123	Continued From pa	ge 7	C 123			
	person replace the door hardware with single action hardware. Provide documentation of the repairs.					
	2. Observations revealed a set of steps from the sliding door exit out of the living room. The steps did not have handrails. Have a qualified person install handrails on either side of the steps. Provide documentation of the repairs.					
C 125	Floors		C 125			
	material and so cor cleanable. b. Scatter or throw					
		e observed on the floor in ove all of the throw rugs.				
	#3 was badly stained	vealed the carpet in Bedroom ed. Have a qualified person e flooring in Bedroom #3. tion of the repairs.				
	Bedroom #2 was bu stained. Have a qu	vealed that the carpet in unching and was badly alified person replace the boom. Provide documentation				
	4. Observations re	vealed that the door to the hall				

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bath had been enlarged. The floor finish had not

AND DUAN OF CODDECTION DENTIFICATION NUMBER.		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION 01	(X3) DATE COMF	SURVEY PLETED	
FCL009008		B. WING 05/22/2		22/2015		
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, S	STATE, ZIP CODE		
OAK GRO	OVE FAMILY CARE H	ONE	FRAS ROAL ORO, NC 2			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETE DATE
		e the wall was cut back. Have epair the floor finish. Provide	C 125			

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